MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

63-045465 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11503

FILED DEC - 2 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

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BY AFFIDAVIT OF

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.

Length of stay in 1b: 88 days

c. CITY OR TOWN St. Louis

Inside Limits: Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Chronic

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4063 Washington

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Adolph		Gaters	10	27	1963

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HR Hours / Min.
Male	Negro		11-10-04	58		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Unknown		Unknown	Unknown

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
William Gaters	Victoria Avont	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of servi

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Chronic Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Broncho Pneumonia	four days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Quadraplegia	1 1/2 Yrs
DUE TO (c)	Dislocation cervical vert	1 1/2 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

352x

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-16-63 to 10-27-63 and last saw her him alive on 10-27-63

Death occurred at 12:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M D

22b. ADDRESS Obama Hosp

22c. DATE SIGNED 10/25/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 11-30-63

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS MO. ANATOMICAL BOARD, 1402 S. GRAND

25. DATE RECD. BY LOCAL REG. NOV 21 1963

26. REGISTRAR'S SIGNATURE Hoard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.